STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, NEW LONDON, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS ✓ Correction date: 11/24/25 KG The following deficiencies resulted from investigation of facility reported incident #2624801-I conducted October 7, 2025 to October 14, 2025. Facility reported incident #2624801-I resulted in deficiencies. Findings for facility reported incident #2624801-M will be sent to the facility at a later date under separate cover. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0602 SS = E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on Facility Reported Incident Review, staff interview, resident interview, narcotic log review, clinical record review, and facility policy review the facility failed to ensure residents remained free from misappropriation of narcotic pain medications for six of nine residents reviewed for misappropriation (Resident #1, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9). The facility reported a census of 45 residents. Findings include:	F0602	F602 1: Resident #1 pain evaluation completed, medication orders have been reviewed, and narcotic log is current Resident #5 pain evaluation completed, medication orders have been reviewed, and narcotic log is current Resident #6 pain evaluation completed, medication orders have been reviewed, and narcotic log is current Resident #7 pain evaluation completed, medication orders have been reviewed, and narcotic log is current Resident #8 pain evaluation completed, medication orders have been reviewed, and narcotic log is current Resident #9 pain evaluation completed, medication orders have been reviewed, and narcotic log is current 2: Current residents have potential to be affected. 3: Staff received education for administration of medications, proper wasting, immediately reporting discrepancies to DON, proper documentation of Narcotics in the MAR. 4:DON or designee will perform audits to monitor administration of medications, proper wasting, immediately reporting discrepancies to DON, proper documentation of Narcotics in the MAR weekly for four weeks then monthly for four months. Results of the audit will be submitted to the QA team. Date of correction: 11/24/2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
BOMahue	Administrator	11/24/25

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F0602 SS = E	Continued from page 1 1.Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 9/11/25 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident took opioid medication (narcotic pain medication). The Care Plan dated 6/10/25 revealed, I use opioid medications related to pain. The Intervention dated 6/10/25 revealed, Administer opioid medication as physician ordered and monitor for side effects. The Physician Order dated 7/23/25 revealed the resident prescribed Oxycodone 5mg (milligrams), a narcotic pain medication, to be administered every six hours as needed, and also had an order dated 9/9/25 for Oxycodone 5mg, a narcotic pain medication, to be administered four times a day for pain/discomfort. Review of Narcotic Logs for Resident #1 revealed on 9/1/25, Staff A removed Oxycodone 5mg from the resident's narcotic card in the following order: a. 9/1/25 at 7:10 PM: Staff A signed out 1 pill, which lowered medication count to 26. (Narcotic Log Page 26). b. 9/1/25 at 5:50 PM: Staff A signed out 1 pill, which lowered medication count to 25. This medication dose marked as wasted (destroyed). (Narcotic Log Page 47). c. 9/1/25 at 7:10 PM: (Time that been entered already on narcotic log): Staff A signed out 1 pill, which lowered medication count to 24. (Narcotic Log Page 47). Review of the Investigation Drug Diversion 9-13-25 revealed, It was found that [Staff A] adjusted narcotic starting number and duplicated the orders, and documented this practice had been done by Staff A for Resident #1. Review of the staff statement by Staff F, Licensed Practical Nurse (LPN), included as part of a Facility Reported Incident (FRI) Investigation revealed the following: While passing noon medications on 9/13/25 [Staff F] noticed that [Resident #1's] Oxycodone (narcotic pain medication) 5mg (milligram) blister pack had multiple slots taped. [Staff F] made a comment to the other nurse on staff who also thought this was odd. Upon inspecting the pill in slot 40, [Staff F] noticed that it did not match the other pills in the pack. [Staff F] looked up the pill description and concluded that it was an Amlodipine Besylate (blood pressure medication) 5mg and not an Oxycodone 5mg....[Staff F]	F0602		

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F0602 SS = E	Continued from page 2 then inspected the other Blister packs in the Narcotics drawer. [Staff F] found more tape on the back of [Resident #5's] Oxycodone 5mg card, [Staff F] reported this additional finding to the DON (Director of Nursing). On 10/7/25 at 1:45 PM, Staff B, LPN queried if had any concerns with narcotics, and responded not anymore. Staff B explained she had just kept noticing there was tape on the back of some of the narcotics now and then, and was kind of starting to figure out who narrowing down to. Per Staff B, she never came across one with tape that she had to give. Staff B explained she didn't bring it up, was waiting on see what was going on, and realized when doing count was tape on the back of the card, described by Staff B to throw (her) off sometimes. When queried if reported to the DON, Staff B responded no, sometimes could pop, tape, initial, explain, and said no one ever said hey, this is what happened. Per Staff B, she felt extra tape, and didn't think anything of it. Per Staff B, seemed to have happened more often, was always finding on the same side of building, Staff B didn't know for sure, and if would have known for sure, would have brought something up. Staff B explained she did not notice if one drug or different drugs taped. When queried how long of a time frame she noticed/felt tape, Staff B responded probably a month. When queried if it ever came up in conversation with other staff, Staff B reported she and Staff F worked together one day, and Staff F said why is there so much tape? Staff B said check to make sure. Staff B reported she started to notice in August. On 10/9/25 at 1:13 PM, Staff F explained he went to give a resident [Resident #1] his noon dose of Oxycodone, and the card had tape on the back of it and pill taped back in. Staff F explained he thought it was odd, looked at the card, and a bunch of different slots had tape on them. Staff F explained looked over to the other nurse (later identified by Staff F as Staff B), what's going on with all the tape? Per Staff F, she said she didn't know. Staff F explained he inspected the pill, it wasn't Oxycodone, and was Amlodipine 5mg. When queried if it was in the bubble pack with the tape, Staff F confirmed it was. Staff F explained at that point he notified the DON (Director of Nursing). When queried if if was the first dose for Resident #1 that day, Staff F said no. Staff F explained had given AM dose that morning. When queried how that bubble (medication bubble in card) looked, Staff F explained that had been the same situation. When queried if AM dose also had tape, Staff F responded yes, at first he (Staff F) thought maybe somebody accidently popped it while popping previous one, and when he came across	F0602		

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F0602 SS = E	Continued from page 3 second dose with tape, said this is not a one off thing, and was weird. Staff F explained it was like scotch tape. When queried how the Amlodipine looked versus the Oxycodone, Staff F responded after he looked at the two different and the pill descriptor, both were the same size, both were white, and one side was identical on both of them. Staff F then explained the markings on the pills. Staff F explained Oxycodone was scored (had indented line on pill), and when looking at it noticed the score was missing, which prompted him to look more at the markings/look up online. Review of information included as part of a Facility Reported Incident (FRI) dated 9/13/25 revealed, [Name Redacted] DON was notified that there is an Oxycodone blister pack that had taped slots. The pill in the taped blister pack slot was inspected and was identified as Amlodipine Besylate 5mg. During investigation it was found that the frequency of administration of PRN (as needed) Narcotics is greater from [Staff A] (Licensed Practical Nurse, LPN) than any other nurse. Narcotics are being wasted more frequently by [Staff A] than any other nurse. [Staff A] has documented the narcotic as given in the Narcotic book but at times has not documented it in the MAR (Medication Administration Record). Discrepancy found in the Narcotic book with double documenting of narcotics when continuing the drug to a new page in Narcotic book. Employee interviews lead to determination that the medications were taped when [Staff A] was signed on the cart. Review of the Disciplinary Action Form for Staff A dated 9/16/25 revealed the employee was terminated due to the following: Suspect in drug diversion-Substantiated. 2. Review of the MDS assessment dated 7/30/25 revealed Resident #5 scored 3 out of 15 on a BIMS exam, which indicated severely impaired cognition. Per this assessment, the resident had diagnoses of cancer, arthritis, and non-Alzheimer's dementia. Per this assessment, Resident #5 took opioid medication. Review of Resident #5's Care Plan dated 7/24/25 revealed, I have chosen to recieve hospice care with [Name Redacted] hospice. The Intervention dated 7/24/25 revealed, Coordinate with the hospice team to assure I experience as little pain as possible. Review of the Physician Order dated 7/25/25 revealed the resident could receive 1 tablet of Oxycodone 5mg by mouth twice daily as needed, and the additional order active 8/15/25 to 9/12/25 revealed, Oxycodone Hcl Oral	F0602		

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F0602 SS = E	Continued from page 4 Tablet 5mg with instructions to give 5mg by mouth three times a day for pain. Review of Resident #5's Narcotic Log (Page 49) revealed on 9/9/25 at 4:50 PM, Staff A removed one dose of the medication (lowered count to 26). Review of Resident #5's Narcotic Log (Page 62) revealed on 9/9/25 at 4:50 PM, Staff A removed one dose of the medication (lowered count to 25). Staff A removed one dose at 6:45 PM (lowered count to 24), and at 9:40 PM (lowered count to 23). On 9/9/25 Staff A removed four doses of Oxycodone 5mg, while three doses of Oxycodone 5mg were charted by Staff A on the MAR. Review of Resident #5's MAR dated September 2025 revealed between 9/1/25 and 9/13/25, Staff A documented they administered 17 of 20 doses of PRN Oxycodone. 3. Review of the MDS dated 7/14/25 for Resident #6 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident took opioid medication. The Care Plan dated 7/8/25 revealed, I use opioid medication related to pain from pressure ulcers and hx (history) of CVA (cerebrovascular accident). The Intervention dated 7/8/25 revealed, Administer opioid medication as physician ordered and monitor for side effects. The Physician Order dated 8/18/25 revealed Oxycodone Hcl Oral Tablet 5mg with directions to give one tablet by mouth three times a day for pain. The Physician Order dated 8/20/25 revealed Oxycodone Hcl Oral Tablet 5 mg with directions to give one tablet orally every 12 hours as needed for pain May take PRN with the scheduled dose. Review of the Investigation Drug Diversion 9-13-25 provided by the facility revealed Resident #6's Oxycodone dated 9/9/25 at 3:25 PM was not documented on the resident's MAR. Review of Narcotic Log (Page 51) revealed Staff A removed a tablet of the medication on 9/9/25 at 3:25 PM, and removed another tablet of the medication on 9/9/25 at 7:20 PM. Resident #6's MAR dated 9/6/25 revealed Staff A documented she administered only the resident's scheduled HS (evening) Oxycodone 5mg dose that day, with no PRN doses given by Staff A. 4. Review of the MDS dated 9/25/25 for Resident #7 revealed the resident scored 14 out of 15 on a BIMS exam, which indicated intact cognition. Per this	F0602		

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F0602 SS = E	Continued from page 5 assessment, the resident took opioid medication. The Care Plan dated 10/6/23 revealed, I use opioid medications related to sciatic pain. The Physician Order dated 10/5/23 for Resident #7 revealed, Hydrocodone-Acetaminophen Oral Tablet 5-325 with instructions to give one tablet by mouth every 6 hours as needed (PRN) for pain. The Investigation of Drug Diversion 9-13-25 provided by the facility reveled from 8/21/25 to 9/12/25, Resident #7 received 27 doses (Hydrocodone-Acetaminophen) by Staff A, and 9 doses from other nurses, and when interviewed resident, he stated he stated he rarely asked for pain medication. Review of Resident #7s Medication Administration Record (MAR) dated September 2025 revealed from 9/1/25 to 9/13/25, Staff A documented they administered 18 of 21 doses of PRN Hydrocodone Acetaminophen. Continued review of the resident's MAR revealed from 9/13/25 to 9/30/25, Resident #7 received one dose total of PRN Hydrocodone-Acetaminophen, administered on 9/20/25. Continued review of the resident's MAR revealed Staff A administered two doses of PRN Hydrocodone-Acetaminophen to Resident #7 on the following dates: 9/1/25, 9/2/25, 9/4/25, 9/6/25, 9/7/25, 9/9/25, 9/10/25, 9/11/25, and 9/12/25. The Focused Evaluation Note dated 9/8/25 at 12:53 AM revealed no pain or discomfort observed or reported for Resident #7 for the shift. Review of the Focused Evaluation Note dated 9/10/25 at 8:58 AM noted Resident #7 denied any pain. Review of the Narcotic Log (Page 28) for Resident #7's Hydrocodone/APAP (Acetaminophen) 5/325 mg revealed on the last line of the narcotic record, dated 9/10/25 at 8:45 PM, Staff A had removed one pill (lowered medication count to 26). Review of the Narcotic Log (Page 64) revealed for the first line on the new log, Staff A again charted the same date and time (9/10/25 at 8:45 PM), and lowered the medication count by one pill (lowered medication count to 25). Narcotic Log review revealed two pills had been removed by Staff A for one date and time. The Focused Evaluation Note dated 9/11/25 at 9:25 AM revealed Resident #7 denied any pain. The Focused Evaluation Notes dated 9/12/25 revealed the	F0602		

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F0602 SS = E	Continued from page 6 following: a.9/12/25 at 3:55 AM; Resident #7 had no complaints of pain or discomfort observed or reported for the shift. b. 9/12/25 at 8:43 AM: Resident #7 denied any pain. Review of Resident #7's Pain Interview dated 9/13/25 revealed the resident denied pain or hurting any time in the last 5 days. Review of Resident Interview responses for Resident #7 dated 9/13/25 included as part of the FRI included, in part, he following questions and answers: Do you feel your pain is controlled? Yes. Have you been receiving (asking for as needed) pain medication? No. On 10/8/25 at 1:01 PM, interview with the ADON revealed the following: The ADON explained she had worked a Thursday and stayed overnight to provide one to one (resident monitoring) prior to the incident. The night the ADON worked, the ADON did a partial narcotic audit of the book versus the MAR, and explained she did not get into the actual (narcotic) drawer. The ADON explained she had noticed for multiple residents, Staff A would waste a med with the nurse, would waste a narcotic, then an hour later would give the narcotic to multiple people. The ADON further explained Staff A would give a lot of narcotics in short sequence, and explained noticed Staff A gave a lot of narcotics to Resident #7. The ADON further explained she had known Resident #7 for many years, had cared for Resident #7 at another facility, some days he would take two or one Vicodin (Hydrocodone Acetaminophen) for the day, and Staff A was administering to the resident as soon as could have them, like three times a shift. The ADON explained she thought it was odd, and had just told Staff A that night if pulled a med and can't give, to waste it. When queried if Staff A wasted a lot, the ADON responded Staff A would waste an Oxycodone, hour later would give one, was wasting a lot, and in short order would give another. The ADON explained she thought it was weird, and the next morning (Friday), she told the Director of Nursing (DON) about Staff A wasting a lot of narcotics. The ADON further explained she didn't want to jump to that conclusion, it looked odd, something wasn't right, and the DON was going to talk to Staff A about the wasting. When queried if she asked Resident #7 about what she had seen, the ADON explained she did not, it was night time, and the resident would have been sleeping. Per	F0602		

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F0602 SS = E	Continued from page 7 the ADON, that is why took to the DON so could go from there. When queried if had asked Resident #7 about it from that time to current (up to 10/8/25), the ADON responded she had not, and the DON took over the lead. Per the ADON, she had noticed it was Oxycodone and Vicodin, and for patient on that, were maxing out. The ADON explained if twice a day and every 6 hours PRN, medication was being given twice a day and every 6 hours PRN. On 10/9/25 at 1:13 PM, Staff F queried about Resident #7's pain. Staff F explained typically the resident would say 2 or 3 at most (pain level), and when asked if the resident wanted anything, Tylenol or pain pill, resident would tell him no, 2 or 3 was pretty normal for him. On 10/9/25 at 3:50 PM, the MDS Coordinator queried if any narcotic concerns, stated no, said she took that back, and explained the following: The MDS Coordinator explained did a narcotic audit a week before incident occurred (with Amlodipine), and noticed Staff A signing out all the PRNs. The MDS Coordinator explained she mentioned it to the DON, and were watching. The MDS Coordinator further explained she didn't normally do the audits, and were helping the DON do the audits that week. Per the MDS Coordinator, PRNs were a lot more than most nurses. When queried if any specific residents stuck out to her, the MDS Coordinator mentioned Resident #7, "extremely", and Resident #8. When queried why Resident #7, the MDS Coordinator explained when she worked the floor, on-call worked the floor, the resident never complained of pain for her. She thought it was very weird every time staff member worked was getting PRN narcs when never complained of pain. The MDS Coordinator explained she was the person who had done the resident pain interviews (part of Facility Reported Incident Investigation), and Resident #7 said he never had pain and did not need pain meds. When queried if she (MDS Coordinator) asked Resident #7 if [Staff A] gave him the medication, the MDS Coordinator responded no, she never said (Staff A's) name, asked the questions and moved on. The MDS Coordinator then explained it was probably about 4 days before notified about taped med that did the audit. On 10/13/25 at approximately 1:50 PM, Resident #7 was interviewed in his room. Resident #7 queried about his pain, and responded was real good. When asked to rate his pain on scale of 0 to 10, Resident #7 responded was 5 or 6 in hip area. When queried if he took anything for it, Resident #7 responded no, and denied requesting in September. When queried if he took more than one PRN	F0602		

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F0602 SS = E	Continued from page 8 dose in a day, Resident #7 responded no. When queried what made it better, Resident #7 responded laying here. 5. The MDS Assessment for Resident #8 dated 9/11/25 revealed Resident #8 scored 15 out of 15, which indicated intact cognition. The MDS revealed resident ranked pain as score of 01 when assessed on 00-10 scale (with 0 being no pain and 10 being worst pain you can imagine). The Care Plan dated 5/30/25 revealed, I have pain related to my current diagnosis. The Intervention dated 5/30/25 revealed, Anticipate my need for pain relief and respond immediately to any complaint of pain. On 10/9/25 at 3:50 PM, continued interview with the MDS Coordinator revealed the following for Resident #8: When the MDS Coordinator interviewed the resident, Resident #8 said did have pain, but she had requested her narcs to be discontinued because she did not want to take narcotics. The MDS Coordinator then said mostly all the PRNs were from Staff A for her (Resident #8) too. Review of Physician Orders for Resident #8 revealed from 7/28/25 to 9/15/25, the resident had Hydrocodone Acetaminophen 5-325 mg one time a day for pain (scheduled), and starting 6/28/25 was ordered Hydrocodone Acetaminophen 5-325, with directions to give 5mg every 6 hours as needed (PRN). Review of Resident #8's September 2025 MAR revealed Staff A administered scheduled Hydrocodone/Acetaminophen to the resident on 9/1/25, 9/2/25, 9/4/25, 9/9/25, 9/10/25, 9/11/25, and 9/12/25. Staff A administered 11 of 13 PRN doses of the PRN medication given between 9/1/25 and 9/13/25, administered on the following dates/times: a. 9/1/25 at 4:40 PM b. 9/2/25 at 5:30 PM c. 9/4/25 at 4:00 PM d. 9/6/25 at 9:00 AM e. 9/6/25 at 4:20 PM f. 9/7/25 at 8:20 AM g. 9/7/25 at 3:26 PM h. 9/9/25 at 5:16 PM	F0602		

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F0602 SS = E	Continued from page 9 i. 9/10/25 at 4:10 PM j. 9/11/25 at 4:00 PM k.9/12/25 at 3:40 PM Review of a Resident Interview form dated 9/13/25 for Resident #8 conducted as part of the FRI investigation the following: Resident #8 had not asked for pain meds because Resident #8 did not want to take narcotics, and Biofreeze (topical non-narcotic for pain) worked well. Review of Resident #8's Progress Notes revealed the following: The Skilled Evaluation Note dated 9/13/25 at 9:27 PM revealed Resident #8 refused the scheduled dose of bedtime Hydrocodone and stated she no longer wants it. Per the note, the Nurse Practitioner was faxed for order to discontinue bedtime Hydrocodone, and Resident #8 stated no longer wants. The Encounter Progress Note dated 9/15/25 at 12:00 AM stated, Last visit patient stated that she was having minimal discomfort and did not need her Norco (narcotic pain medication) much longer. She was only taking at HS (evening). Today she denies having any pain and wishes to d/c (discontinue) it. On 10/13/25 at 11:21 AM, Resident #8 interviewed in her room. When queried about her medications, Resident #8 said, just tell them don't want no narcotics. Resident #8 explained had previous bad experience with narcotics at a different nursing facility. When queried about September, Resident #8 acknowledged she had pain, explained the facility had tried to give her Oxycodone (narcotic pain medication) a few times, she had refused it, and told the doctor she didn't want narcotics. Per Resident #8, the doctor said would keep her on Dilaudid (narcotic pain medication) so she had a PRN (as needed), and Resident #8 said she didn't want it. Resident #8 said all she took was Tylenol (non narcotic medication) and Biofreeze (topical non-narcotic medication), explained she got by unless it was a really bad day, and said she would not take a narcotic ever again. When queried if she would take a narcotic on the days where Tylenol and Biofreeze were not effective, Resident #8 responded no. Resident #8 explained she thought she had Oxycodone, and Resident #8 explained was almost 100% sure she refused every time. When queried to her knowledge, if she had requested a PRN narcotic in September, Resident #8 denied, because didn't want it. Resident #8 explained	F0602		

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F0602 SS = E	Continued from page 10 Staff A had offered resident a PRN, and Resident #8 didn't want it. 6. Review of the MDS assessment for Resident #9 dated 7/10/25 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident took opioid medication. Review of Resident #9's Care Plan dated 2/3/25 revealed, I use opioid medications related to chronic pain. The Intervention dated 2/3/25 revealed, Administer opioid medication as physician ordered and monitor for side effects. The Physician Order dated 6/23/25 revealed Resident #9 was ordered Hydrocodone Acetaminophen 5-325 mg with directions to administer one tablet by mouth three times a day (scheduled). The resident was also prescribed Hydrocodone Acetaminophen 5-325 with directions to administer one tab by mouth as needed for pain, and could take two times a day as needed for breakthrough pain. Review of the Narcotic Log (Page 50) for Resident #9's Hydrocodone Acetaminophen revealed on 9/6/25, Staff A removed a dose of the resident's medication at 6:40 AM (lowered count to 57), 12:45 PM (lowered count to 56), and 2:20 PM (lowered count to 55). A dosage of the medication was removed at 5:45 PM (lowered count to 55), with no nurse signature present on the log. A different nurse removed a dosage of the medication at 7:15 PM (lowered count to 53). Five doses of the resident's medication were removed from the resident's medication supply on 9/6/25. Review of Resident #9's September 2025 MAR revealed on 9/6/25, Staff A signed out two scheduled doses of the medication, on MAR for AM and Mid, and another nurse signed out the resident's scheduled evening dose. The MAR revealed one PRN dose administered on 9/6/25, administered at 5:41 PM. The MAR revealed on 9/6/25 four doses of the medication were administered to Resident #9. The Investigation Drug Diversion 9-13-25 document revealed Staff A adjusted narcotic starting number and duplicated the orders (would remove multiple pills for the same date/time across different narcotic log pages) for Resident #9. Continued review of the Narcotic Log (Page 50) revealed on 9/11/25, Staff A removed a dose of the medication at 4:15 PM (count lowered to 31), then removed a dose of the medication at 8:15 PM (count lowered to 30),	F0602		

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F0602 SS = E	Continued from page 11 completing the last line on Narcotic Log (Page 50). Staff A began a new Narcotic Log sheet (Page 65), entered removal of a dose on 9/11/25 at 8:15 AM for the second time (as had already been documented on Page 50), and lowered the amount remaining to 29. Staff A next removed a dose at 9:40 PM (count lowered to 28). Review of the resident's September 2025 MAR revealed on 9/11/25, Staff A administered one scheduled dose of the medication at HS (evening), and two PRN doses, one at 4:15 PM and the other at 9:40 PM. Review of Resident #9's MAR dated September 2025 revealed from 9/1/25 to 9/12/25, Staff A documented they administered 16 of 17 doses of PRN Hydrocodone Acetaminophen. Staff A administered two doses of the resident's PRN medication to Resident #9 on 9/2/25, 9/7/25, 9/9/25, 9/10/25, 9/11/25, and 9/12/25. The resident's September 2025 MAR revealed the only times during the month the resident recieved two PRN doses of the medication was when Staff A worked. Resident #9 received three doses total of PRN Hydrocodone Acetaminophen between 9/13/25 and 9/30/25. On 10/9/25 at 12:13 PM, the DON explained the following: The ADON said had talked to Staff A about not taping medications, and had provided education. The DON learned of this on Friday (9/12). The ADON had done a narcotic audit, had noticed some wasting was off in the book, Staff A would waste, indicated was the wrong resident, and an hour later would give the medication. The DON explained she talked with Staff A on Friday, thought Staff A maybe needed some help, and DON asked Staff A what was wrong. The DON explained Staff A responded they got distracted and liked to help the CNAs (Certified Nursing Assistants). Per the DON, she provided education to Staff A about focus on medication pass. The DON explained on Friday night, per Staff H's statement included as part of FRI, Staff A reported she got in trouble for taping/wasting narcotics. The DON explained this information wasn't communicated to the DON until Saturday. On Saturday, Staff F called the DON because he had a taped med. Staff F looked at the pill, punched it out, it looked a lot like Oxycodone, and it was not Oxycodone. Per the DON, Staff F looked it up, and it was Amlodipine. This was for Resident #1. The DON further explained it was identified there was a problem, and the DON interviewed multiple staff who worked Friday and overnight who denied taping medications.The DON explained the ADON had previously talked to Staff A about taping medications. Per the DON, there was only one other person who had been on that cart, which was Staff A. The DON further explained Staff A was suspended related to being suspect in drug	F0602		

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F0602 SS = E	Continued from page 12 diversion, and was terminated due to results of investigation, where in house investigation was founded for drug diversion. The Facility Policy titled Investigating Incident of Theft and/or Misappropriation of Resident Property revised April 2021 revealed, Residents have the right to be free from exploitation, theft and/or misappropriation of personal property.	F0602		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on Facility Reported Incident Investigation, staff interview, narcotic log review, clinical record	F0755	F755 1: Resident #1 medication orders have been reviewed, and narcotic log is current Resident #5 medication orders have been reviewed, and narcotic log is current Resident #6 medication orders have been reviewed, and narcotic log is current Resident #7 medication orders have been reviewed, and narcotic log is current Resident #8 medication orders have been reviewed, and narcotic log is current Resident #9 medication orders have been reviewed, and narcotic log is current 2: Current residents have potential to be affected. 3: Staff received education for administration of medications, proper wasting, immediately reporting discrepancies to DON, proper documentation of Narcotics in the MAR. 4: DON or designee will perform audits to monitor administration of medications, proper wasting, immediately reporting discrepancies to DON, proper documentation of Narcotics in the MAR weekly for four weeks then monthly for four months. Results of the audit will be submitted to the QA team. Date of correction: 11/24/2025	

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F0755 SS = E	Continued from page 13 review, and facility policy review, the facility failed to ensure safeguards were consistently implemented to account for all narcotic medications in the facility and timely identify suspected drug diversion, and failed to ensure completion of narcotic logs per accepted standards of practice for five of nine residents reviewed for pharmacy services (Resident #1, Resident #5, Resident #6, Resident #7, Resident #9). The facility reported a census of 45 residents. Findings include: Review of information included as part of a Facility Reported Incident (FRI) dated 9/13/25 revealed, [Name Redacted] DON (Director of Nursing) was notifed that there is an Oxycodone blister pack that had taped slots. The pill in the taped blister pack slot was inspected and was identified as Amlodipine Besylate (blood pressure medication) 5mg. [Staff A] has documented the narcotic as given in the Narcotic book but at times has not documented it in the MAR (Medication Administration Record). Discrepancy found in the Narcotic book with double documenting of narcotics when continuing the drug to a new page in Narcotic book. Employee interviews lead to determination that the medications were taped when [Staff A] was signed on the cart. Review of a Witness Statement by Staff F, Licensed Practical Nurse (LPN), included as part of the FRI Investigation revealed the following: While passing noon medications on 9/13/25 [Staff F] noticed that [Resident #1's] Oxycodone (narcotic pain medication) 5mg (milligram) blister pack had multiple slots taped. [Staff F] made a comment to the other nurse on staff who also thought this was odd. Upon inspecting the pill in slot 40, [Staff F] noticed that it did not match the other pills in the pack. [Staff F] looked up the pill description and concluded that it was an Amlodipine Besylate (blood pressure medication) 5mg and not an Oxycodone 5mg....[Staff F] then inspected the other Blister packs in the Narcotics drawer. [Staff F] found more tape on the back of [Resident #5's] Oxycodone 5mg card, [Staff F] reported this additional finding to the DON. Review of a Witness Statement by Staff C, LPN dated 9/13/25 revealed when queried if noticed any taped narcotics on their cart, responded maybe only one. Review of a Witness Statement by Staff G, LPN dated 9/15/25 revealed, in part, she had noticed taped meds over the last week, and had also noticed narcs (narcotics) were being wasted more frequently by [Staff	F0755		

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F0755 SS = E	Continued from page 14 A]. ...have noticed taped meds over the last week. I also noticed narcs were being waisted more frequently by [Staff A]. Review of a Witness Statement by Staff H, Registered Nurse (RN) dated 9/13/25 revealed, in part, When [Staff H] reported to my shift [Staff H] asked [Staff A] to count. She stated she was not ready to count that she got in trouble for Tapeing and waisting narcotics. She was charting in Narc book. On 10/7/25 at 1:45 PM Staff B, LPN queried if had any concerns with narcs (narcotics), and responded not anymore. Staff B explained just kept noticing there was tape on the back of some of the narc now and then, and she was starting to notice. Per Staff A, was kind of starting to figure out who to narrow down to, and she never came across one with tape that she had to give. Staff B explained she didn't bring it up, and waited to see what was going on. Per Staff B, she realized when doing count there was tape on back on the cards, and would throw [person] off sometimes. When queried if reported to the DON, Staff B responded no. Staff B explained she had felt extra tape, and didn't think anything of it. Staff B explained it seemed to be happening more often. Staff B explained was always finding on same side. Staff B explained she narrowed down that staff member worked full time on that side, and seemed to always find on that side. Staff B further explained she didn't know for sure, and if would have known for sure, would have brought something up. On 10/8/25 at 10:08 AM, Staff C, LPN queried if any issues with narcotics, and responded did have some issues, one of the nurses actually. Staff C responded when counted one day, the ADON (Assistant Director of Nursing) mentioned to Staff C there were some taped meds, and said she was going to address it. Staff C explained it was mainly the other cart, and may have been one card on her cart that had tape on it. When queried if she (Staff C) saw tape on a card in her cart, Staff C acknowledged did, and explained she didn't remember whose it was, and thought it was a PRN (as needed) card. When queried if it was a narcotic, Staff C acknowledged it was. When queried when it might have been roughly, Staff C explained she thought probably the Monday or Tuesday before the incident. Per Staff C, the ADON wokrked the over night shift, she filled in for night shift so they counted together in the morning, and the ADON brought up noticed taped meds, and she had said she was going to address with the evening nurse. When queried if proceed with count (narcotic count) with taped one in there, Staff C said yeah thre was one, and was not sure if ADON said	F0755		

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F0755 SS = E	Continued from page 15 something so then they just saw it. When queried if she examined the card, Staff C responded could see there was a pill taped in there, Staff C didn't examine the pill, and it looked the same otherwise would have questioned if looked different. Staff C explained should not tape pills, acknowledged was not normal practice per Staff C, and if got a narc (narcotic) out and someone refused or punched a wrong narc, would find another nurse and destroy it with the other nurse. Staff C explained to destroy, would consign in the book. When queried if prior to incident had training about what to do if taped med, Staff C responded not that she was aware of. Staff C explained there had been training put out that if found a taped med, to notify the DON immediately. On 10/8/25 at 10:37 AM, Staff D, LPN queried if had ever seen narcotics taped. Per Staff D, ADON had noticed, and when ADON pointed it out, Staff D saw it. Per Staff D, the ADON was working either the shift before or after Staff D, and the ADON noticed the tape. When queried if Staff D had noticed it before that point, Staff D responded not really, no. When queried if it had ever come up in counts, Staff D responded no. When queried if she remembered what resident or what drug, Staff D responded they were not one hundred percent, and thought maybe it was Resident #6. When queried if the med with tape had been a narcotic, Staff D acknowledged had been. Per Staff D, could not tape meds, was not allowed, and was not something could do. On 10/8/25 at 1:01 PM, the ADON was queried about narcotic concerns. The ADON explained she wasn't at facility the day Staff F found something in the narcotic card, and the ADON explained she had worked a Thursday before had occurred, and had stayed over to work the night shift due to had one to one (resident requiring one to one monitoring). The ADON explained she heard through the grapevine that Staff A had taped a narcotic in a narcotic card, that she had taped it back. Per the ADON, Staff A happened to be there that night when came in, and ADON sat down and talked to Staff A and said not under any circumstances tape meds back in. Per the ADON, Staff A said ok, and asked to waste them? The ADON explained yes, if pull med and don't give, waste it. When queried about how she learned about the alleged taping, the ADON explained she thought she heard someone talking about it, like nurses, and asked them, said it was Staff A. That's when the ADON went to Staff A. The ADON explained she heard from staff that Staff A had taped something. When queried if she looked at the	F0755		

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F0755 SS = E	Continued from page 16 card, the ADON responded at that point, nothing was taped. The ADON explained she had asked the nurse that was on the cart, and the nurse on the cart told the ADON there were no meds taped. The ADON explained they did not visually look at the cards. Per the ADON, when she spoke to Staff A, Staff A admitted she was taping, and won't do anymore. When queried if Staff A provided explanation to why did that, the ADON responded no. When queried if there was written documentation (regarding tape conversation), the ADON responded no. When queried as to the resident name or drug name for alleged drug, the ADON unaware. When queried which medication cart was affected, the ADON was unsure. On 10/9/25 at 1:13 PM, Staff F explained when he went to give Resident #1's noon dose of Oxycodone, the card had tape on the back of it and a pill taped back in. Staff F explained were a bunch of different slots with tape on them. Staff F explained the resident's AM dose of the medication also had tape on it, at first Staff F thought maybe somebody accidently popped it while popping the previous one, and when came across the second dose taped, said this is not a one off thing. Per Staff F, it was weird. Staff F described the tape as like scotch tape. Staff F described bubbles on the card that were empty, something previously adminsitered, with tape still on the card. When queried if appropriate to tape cards, and if could tape cards, Staff F responded no, not supposed to was his understanding and that was the general rule. On 10/9/25 at 3:07 PM, Staff H, Registered Nurse (RN) explained the following. Staff H went in and worked the night shift, counted with Staff A, and with her count was correct. When Staff H came in, Staff A said she was working on the book (narcotic book). Staff H explained didn't know what was meant by working on the book. Per Staff H, Staff A said she (Staff A) had got in trouble for putting back in and taping up too many drugs, and had been talked to about it. During the interview on 10/9/25 at 3:07 PM, Staff H explained that was a big "no no". On 10/13/25 at 9:57 AM, the DON explained she had heard about taping from the ADON. When queried if she should have been notified if staff noticed taping prior to the education or oingoing, the DON responded yes, [facility] knew didn't do that, would be concern, problem and needed education. On 10/13/25 at 12:08 PM, the Pharmacist queried if ever appropriate for tape on the back of a narcotic medication pack. The Pharmacist responded if needed to take out and put in, it wouldn't be good practice to do	F0755		

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F0755 SS = E	Continued from page 17 that, definitely for a control, and responded it was a grey area. 1.Review of Narcotic Logs for Resident #1 revealed on 9/1/25, Staff A pulled the following Oxycodone 5mg from the resident's narcotic card in the following order: Staff A removed one pill at 7:10 PM, which lowered the medication count to 26. Then, Staff A documented removed one pill at 5:50 PM, destroyed it, then removed another pill at 7:10 PM and lowered the narcotic count of medications remaining again. Two doses had been removed for the same date and time, documented on two separate lines of the Narcotic Logs. Continued review of the Narcotic Log (Page 47) revealed time documentation on the pill removed at 7:10 PM appeared to have been altered, as well as for a dose removed on 9/4/25 at 9:40 PM. The line of the log dated 9/7/25 at 10:20 AM revealed a previous time entry had been scribbled out, with a new time entry written. On 10/9/25 at 3:50 PM, the MDS Coordinator explained for narcotics she would go off the MAR (Medication Administration Record), triple check it, always also look to see when last got it, and if got PRN an hour ago don't want to turn around and give another. When given an example about non-chronological documentation of times, the MDS Coordinator responded that did not make sense, and should sign out when give it. 2. Review of the Physician Order dated 7/25/25 revealed Resident #5 could receive 1 tablet of Oxycodone 5mg by mouth twice daily as needed, and the additional order active 8/15/25 to 9/12/25 revealed, Oxycodone Hcl Oral Tablet 5mg with instructions to give 5mg by mouth three times a day for pain. Review of the Narcotic Log shown below revealed 6 pills of the medication removed for the day, although removal of five pills per day was ordered. Review of the resident's Narcotic Log Page 49 for Oxycodone 5mg revealed on 9/4/25, the resident had received doses of the medication at 7:23 AM, and at 12:22 PM by a different nurse. Continued review of Narcotic Log (Page 49) revealed Staff A removed one tablet of the medication from the resident's medication card at 2:35 PM (count lowered to 49), at 4:30 PM (count lowered to 48), at 7 PM (count lowered to 47), and at 9:30 PM (count lowered to 46). Review of the resident's MAR dated 9/2025 revealed Staff A signed out 4 doses of the PRN medication and one dose of scheduled Oxycodone, although the resident	F0755		

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F0755 SS = E	Continued from page 18 only prescribed two PRN doses daily. Staff A signed the PRN doses on the MAR at 2:33 PM, 2:35 PM, 7:00 PM, and 9:34 PM, which differed from the Narcotic Log page 49. 3. Review of the MDS dated 7/14/25 for Resident #6 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident took opioid medication. The Physician Order dated 8/18/25 revealed Oxycodone Hcl Oral Tablet 5mg with directions to give one tablet by mouth three times a day for pain. The Physician Order dated 8/20/25 revealed Oxycodone Hcl Oral Tablet 5 mg with directions to give one tablet orally every 12 hours as needed for pain May take PRN with the scheduled dose. Review of the Investigation Drug Diversion 9-13-25 provided by the facility revealed Resident #6's Oxycodone dated 9/9/25 at 3:25 PM was not documented on the resident's MAR. Review of Narcotic Log (Page 51) revealed Staff A removed a tablet of the medication on 9/9/25 at 3:25 PM, and removed another tablet of the medication on 9/9/25 at 7:20 PM. Resident #6's MAR dated 9/6/25 revealed Staff A documented she administered only the resident's scheduled HS (evening) Oxycodone 5mg dose that day, with no PRN doses given by Staff A. 4. Review of the Narcotic Log Page 28 for Resident #7's Hydrocodone/APAP (Acetaminophen) 5/325 mg revealed on the last line of the narcotic record, dated 9/10/25 at 8:45 PM, Staff A had removed one pill, which dropped the medication count to 26 pills remaining. Review of the Narcotic Log Page 64 revealed for the first line on the new log, Staff A again charted the same date and time (9/10/25 at 8:45 PM), and dropped the medication count by one pill, which brought the amount remaining to 25 pills. The Narcotic Log Page 28 and Page 64 revealed two pills had been removed for one date and time. Continued review of Narcotic Log Page 64 revealed the following occurred on 9/11/25: Staff A signed out one dose of the medication at 2:45 PM (count lowered to 24), removed another pill at 9:00 PM (count lowered to 23), then charted removed a dose on 9/11/25 at 3:00 PM (count lowered to 22). 5. Review of the MDS assessment for Resident #9 dated 7/10/25 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident took opioid medication.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, NEW LONDON, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = E	Continued from page 19 The Physician Order dated 6/23/25 revealed Resident #9 was ordered Hydrocodone Acetaminophen 5-325 mg with directions to administer one tablet by mouth three times a day (scheduled). The resident was also prescribed Hydrocodone Acetaminophen 5-325 with directions to administer one tab by mouth as needed for pain, and could take two times a day as needed for breakthrough pain. Review of the Narcotic Log (Page 50) for Resident #9's Hydrocodone Acetaminophen revealed on 9/6/25, Staff A removed a dose of the resident's medication at 6:40 AM (lowered count to 57), 12:45 PM (lowered count to 56), and 2:20 PM (lowered count to 55). A dosage of the medication was removed at 5:45 PM (lowered count to 55), with no nurse signature present on the log. A different nurse removed a dosage of the medication at 7:15 PM (lowered count to 53). Five doses of the resident's medication were removed from the resident's medication supply on 9/6/25. Review of Resident #9's September 2025 MAR revealed on 9/6/25, Staff A signed out two scheduled doses of the medication, on MAR for AM and Mid, and another nurse signed out the resident's scheduled evening dose. The MAR revealed one PRN dose administered on 9/6/25, administered at 5:41 PM. The MAR revealed on 9/6/25 four doses of the medication were administered to Resident #9. Review of a Policy document from the pharmacy dated 2/2023 revealed, Each schedule II medication at the facilty shall be recorded on two forms...Controlled Drug Receipt/Proof of Use/Disposition form. The total quantity received from pharmacy and all subsequent doses administered to the resident will be recorded on the Controlled Drug Receipt/Proof of Use/Disposition Form. Every time a dose is given, the Nursing Staff/CMA (Certified Medication Aide) will enter the date and time, dose given, the Nursing Staff/CMA's signature/initial, and the balance remaining in the container...Document in the eMAR (electronic medication administration record) or paper MAR (so your MAR form and Controlled Drug Receipt/Proof of Use/Disposition form show the same information).	F0755		